Guideline for Management of Adult Diabetes - 2008

DISCLAIMER: The following guidelines apply to management of ambulatory patients (18 yrs and older) with a diagnosis of Diabetes Mellitus. These guidelines are designed to serve as a tool for supporting and influencing those health care provider decisions that promote and provide consistent, comprehensive, preventive care. With the goal of improving care system-wide, the guidelines include recommended lab tests, exams, medical checks, and essential education. The guidelines are population-based and therefore intended to be appropriate for most people with diabetes, but not intended to define the optimal level of care that an individual person may need. Clinical judgment may indicate the need for adjustments appropriate to the needs of each particular person (e.g. age, medical condition, or individual glycemic control goal). Visit the American Diabetes Association's website at www.diabetes.org/for-health-professionals-and-scientists/cpr.jsp to see a complete listing of the ADA's Clinical Practice Recommendations. These guidelines were adapted from the ADA Standards Of Medical Care For Patients With Diabetes Mellitus, Diabetes Care Vol 31 S1 2008 and are consistent with the AMA, JCAHO, and NCQA guidelines. These guidelines are an evolving process and, as such, will be reviewed periodically and revised to reflect advances in research and medical knowledge.

Physician/Patient	Recommendation	Frequency
Periodic Assessment	Persons with diabetes should have a diabetic care assessment that should include the following:	
	▪ Blood Pressure (adult target of <130/80)	Each diabetic-care visit
	▪ Assess Cardiovascular Risks: ▫ fixed risks - family history, age >40 years, gender ▫ modifiable risks - smoking, hypertension, dyslipidemia, albuminuria, sedentary lifestyle, obesity, & stress	Annually
	▪ Weight	Each diabetic-care visit
	▪ Visual Foot Exam for diabetics with neuropathy	Each diabetic-care visit
	▪ Comprehensive foot exam using monofilament, tuning fork, palpation and visual inspection should include examining sensation, foot structure/biomechanics, vascular, skin integrity, & discussion of "high risk" feet	Annually
	▪ Review self blood glucose monitoring records	Each diabetic-care visit
	▪ Oral health screening or visualization	Annually
Laboratory Tests & Other Studies	▪ A1c (Note <7% per ADA and <6.5% per AACE/ACE) for patients in general is <7%; for the individual patient is as close to normal (<6%) as possible without significant hypoglycemia	Twice annually or more based on patient's meeting treatment goals & stable glycemic control
	▪ Serum Creatinine and estimated (calculated) GFR	Annually
	▪ Assess urine albumin excretion (NOTE: Role is unclear after diagnosis of microalbunuria and institution of ACEI or ARB and BP control)	Annually
	▪ Lipid profile, preferably fasting: **LDL** (Goal <100 mg/dL) **TRIGLYCERIDES** (Goal <150 mg/dL) **HDL** (Goal Men ≥ 40 mg/dL, Women ≥ 50 mg/dL)	Annually or more based on treatment goals
	▪ Dilated eye exam by eye care professional or retinal photographs read by experts	Annually
Education, Counseling, and Risk Factor Modification	Refer patient to appropriate self-management education by Diabetes Educator, preferably Certified Diabetes Educator (CDE) ▪ Healthy eating & nutrition, refer for medical nutrition therapy as needed ▪ Being Active: regular physical activity ▪ Monitoring: glycemic control, foot care, dental care, skin care ▪ Taking Medication: sick day guidelines for acute illness ▪ Reducing Risks: cardiovascular risk reduction, smoking cessation intervention, secondhand smoke avoidance, weight control, pre-conception counseling ▪ Problem-Solving & Healthy Coping: psychosocial adjustment, depression screening	Annually or more if appropriate
Medical Recommendation	The following medical recommendations should be considered at each visit until therapeutic goals are achieved:	
	▪ Treatment of hypertension to achieve adult target of <130/80	
	▪ Assess need for ACE inhibitor (ACEI) or Angiotensin Receptor Blocker (ARB) and prescribe if indicated. CAD patient with DM Type 1 or 2 should be on ACEI/ARB; patients not placed on ACEI/ARB when indicated should have reasons documented in clinical record.	
	▪ For those with overt CVD and those over 40 with 1 or more other CVD risk factors, statin therapy is recommended regardless of baseline LDL levels	
	▪ Management of cardiovascular risk factors	
	▪ Assurance of appropriate immunization status, including influenza and pneumococcal vaccine	
	▪ Aspirin therapy daily for prevention in those at increased cardiovascular risk with Type 1 and 2 diabetes, unless contraindicated. (Aspirin therapy is not recommended for patients under the age of 30 and is contraindicated under the age of 21 years because of the increased risk of Reye's syndrome.)	

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